STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005028	A. BUILDING: _____ B. WING _____	12/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENRY COUNTY MEMORIAL HOSPITAL	1000 N 16TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This survey was for the investigation of one State hospital complaint. Complaint number: IN00172052 Unsubstantiated; lack of sufficient evidence Date: 12/22/2015 Facility Number: 005028 Henry County Memorial Hospital is in compliance with 410 IAC 15-1.5-5, Medical staff, Hospital Licensure Rules. QA: cjl 02/02/16	S 000		